

ART. XII.—*Treatment of Hemorrhoids*. By WM. E. HORNER, Professor of Anatomy in the University of Pennsylvania.

Two methods of removal are resorted to in the United States; the one immediate excision, the other strangulation by wire ligature. The French practice of the actual cautery, has few or no advocates. The first mode is followed in some cases by enormous and alarming hemorrhage, which in one instance I have known to be ultimately fatal. The wire ligature is occasionally attended with an agonizing and excessive pain, which lasts from two days to a week, depriving the patient of sleep, and sometimes producing general spasm. The above consequences are points of familiar and distressing experience to surgeons.

From four to six weeks are not unfrequently consumed, in the entire course of treatment by excision or the wire. The steps taken by myself present a combination of measures arising from these two dissimilar modes of operating, and leave the patient well, in from two to three weeks in bad cases, and in a shorter time in mild ones.

The plan here recommended, is to calm the rectum by cold water injections for some days before the operation; a precaution, the value of which, I have learned from one of the best and most experienced surgeons we have, my friend Dr. Thomas Harris, of the United States Navy. The rectum being empty at the time of operating, the patient by straining in a squatting posture, forces the tumour or tumours out. He then goes to bed, and rests on the side corresponding with the tumour, and near the edge of the bed. A thick sail needle armed with a large ligature, is then passed transversely through the upper part of the base of the tumour; the needle being removed from the ligature, the two ends of the latter are tied together, so as to form a loop. A stout awl then transfixes the lower part of the base of the tumour in a line parallel with the ligature above.

In a large protruded pile, the usual anal pouches or sacs are much enlarged, and have their orifices pointing downwards. The awl when placed as intended, is between these sacs and the adjoining margin of the anus, and makes the part so firm, that it is more easily operated on subsequently. The inferior third of the base of the tumour is now detached from the anus with a scalpel, the anal sacs, and a corresponding loose fold of skin which commonly exists at the same time with large hemorrhoids, going along with the tumour. Should the tumour recede, the loop above, and the awl below, enable the operator to draw it out. A wire noose is then thrown around the adherent base of the tumour, and drawn perfectly tight, by the aid of a double caoutchouc. This noose occupies the previous incision and it

* See Horner's Anat. vol. ii. p. 40, 5th edition.

may be placed with great accuracy, from the command over the pile derived from the first ligature and the awl.

The tumour, if very large, may now be punctured so as to disgorge its blood. At the end of five hours, the part is perfectly dead by strangulation, the tumour may then be cut off near the wire noose, say three lines from it, for which act in the process of operating, a pair of scissors will do; but what is still better, Dr. Physick's tonsil instrument, owing to the accuracy of its line of incision. The wire noose itself may then be taken away, as the vessels are so compressed and deadened, that no blood will pass through them.

The awl should be removed directly after the wire noose is applied and fixed, but the first loop should be retained for the final act, to wit: the excision of the tumour, as it assists very much. The operation thus completed, an injection of tinct. opii \mathfrak{z} i. in two ounces of thin starch, puts the patient at ease, and he falls into a tranquil sleep.

I have now tried this combination of existing plans in several cases, it has the signal advantage of reducing pain and counteracting hemorrhage, and is decidedly the best for large piles that I have seen used. The description of it is much longer in time than the operative process itself, which when well arranged occupies but a very few minutes, excepting the delay of the wire loop. My confidence in it is such that I now undertake with but little anxiety, cases which I formerly approached with dread. Should other persons be tempted to adopt these rules, I trust that they will find in their own experience a confirmation of mine, and be saved from some of the most appalling scenes in operative surgery.

Where hemorrhoids have existed several years, for many persons submit to them five, ten or twenty years, even more, under a belief of their incurability, or of the hazard of an operation, they will be found complicated with prolapsus of the rectum. In such cases, there are generally three tumours, one for each side of the anus, and a smaller one in front. The judgment of the surgeon here must determine, whether he will dispose of them by one, two or three distinct operations, also how much of the mucous coat of the rectum he will take away with the base of each tumour. No general directions on these points will meet the exigencies of each individual case. In the indurated or fig-like tumour, which is made almost wholly of coagulated lymph like the tumours of the labia interna of dissolute females, the immediate excision is the best process. My remarks are intended for the vascular form of piles, by far the most frequent, in my experience.

I will conclude by stating, that it is of importance to detach well by the incision first alluded to, the base of the tumour from the internal sphincter muscle, without which precaution, we cut through instead of lifting up and removing a plexus of veins at the anus; we also leave thereby unfortunately, a fold of tegument which swells and inflames largely, and the reduction of which swelling gives rise to a treatment as severe and protracted as a common attack of hemorrhoids.